QUESTIONS FROM THE FLOOR

MODERATOR: KAREN DAVIS, PHD

KAREN DAVIS

Trained as an economist, what we have learned from the Commonwealth Fund's presenters strikes me as odd: we have both excess supply and inadequate care. In economics, a market is out of equilibrium if either excess supply or excess demand exist, but nevertheless the present health care system features a surfeit of hospital beds and physicians, yet many Americans are going without care. As Mr. Sandman's presentation reveals, we have learned that even in New York City, which has some of the nation's best academic health centers and an extensive public hospital system, there are many who go without needed care.

QUESTION FROM BRADFORD GRAY, NEW YORK ACADEMY OF MEDICINE

My question goes to Dr. Biles and has to do with a finding that I noticed in one of the recent reports of the Prospective Payment Assessment Commission (ProPAC). This goes to the question of the differences between private hospitals and public hospitals with regard to uncompensated care. ProPAC uses American Hospital Association numbers and shows very little difference between for-profit and nonprofit hospitals in the amount of uncompensated care, but quite a lot of difference between private and public hospitals, with the latter giving sometimes two or three times as much uncompensated care.

ProPAC did something that I had not seen before. They did a second analysis in which they added into the equation the public subsidies that the hospitals were receiving. The amount of difference between the private and the public hospitals virtually disappeared. Therefore, my question is, Do any of the Commonwealth analyses help us understand better whether it makes a difference if the care is paid for in a subsidy to the institution, as opposed to being attached to the uninsured person?

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KAREN DAVIS

We have to be able to pay for the care to be provided. The first way it could be paid for is insurance coverage; much of our presentation has focused on that. Even for institutions that try to provide free care, there is no free lunch; public subsidies, whether from state and local government, or the federal government through specific subsidies such as payments to disproportionate share hospitals, are a very important source of the payments.

The remainder of the free care, we presume, is provided by being able to charge a surplus to privately insured patients, and that hospitals can use some of the surplus to offset losses on uninsured or undercompensated care. The great concern is that, with managed care, that surplus will be compromised as patients are moved out of institutions that serve the uninsured. In the present fiscal budgetary climate at the federal, state, and local government levels, one worries about public subsidies that have been available in the past. One of the policy issues is the need to better target, for example, federal funding under provisions such as disproportionate share hospital payments so that we make sure they are really going to institutions that are willing to provide care to those who cannot pay.

BRIAN BILES

Two points should be mentioned. The Georgetown findings suggest that we are seeing increased concentration. As the private hospitals reduce their numbers of uncompensated patients and as the number of the uninsured increase, there are substantial increases on the public side. Even if state, county, and private support remains the same, or even adjusted for inflation, more and more patients are concentrating in public facilities.

The second point is that all of the debate, particularly at the national level, is being focused on reducing government spending. We also know, however, that those very same pressures are present at the state, county, and local levels. Although there is much discussion about the erosion of insurance, there is an equal concern about state, county, and local support: is it keeping up with the demand, or is it itself eroding?

QUESTION FROM ROZ LASKER, DIRECTOR, DIVISION OF PUBLIC HEALTH, NEW YORK ACADEMY OF MEDICINE

The data presented here are very disturbing and were considered in the earlier part of the 1990s, when the Health Care Reform Act was being discussed. That is, the burden of being uninsured falls most heavily on the uninsured themselves. At the time, that information was not sufficient to drive changes in policy and address the problem.

My first question is, Are you collecting data that examine who else is bearing the burden of the uninsured rather than the uninsured themselves in terms of

hospitals and uncompensated emergency room costs; in terms of employers who employ these workers and days lost from work and productivity; in terms of the health and potentially the pocketbooks of the middle and upper classes in urban centers, who could be more exposed to disease that is not treated at an early stage in the uninsured? Are you collecting any of this information? Would it be useful in the policy debate?

The second question relates to bringing together the two pieces of this panel this afternoon on the hospitals and on the uninsured. To some extent, you could look at these policy issues as two options for dealing with a problem. To the extent that we cover the disproportionate share for hospitals and uncompensated care, are we creating the illusion that there is a safety net and that emergency rooms are available for the uninsured? Are we decreasing the incentive to provide comprehensive primary care for these patients instead?

CATHY SCHOEN

The low-income project also is doing case studies in the states. We have done an initial round and have published all seven case studies. The two most recent, brought out by the Kaiser Family Foundation, cover Texas and Florida.

One of the discoveries we have made is that, in Tennessee, despite a move that ostensibly insured a much higher percent of the population, the very rapid pace and the lack of planning destabilized the safety net providers in that state. They expected improvements because, suddenly, uninsured people would be insured people, but it didn't quite work out that way. They were losing subsidies from other routes, and uninsured people were still coming; they could not really see a difference in the mix.

Therefore, one of the things we are trying to do in this project (there will be another round of case studies) is to get a broader understanding of the interrelatedness of care. It is clear that the uninsured are becoming much more concentrated, and emergency rooms are not going to be available. In Tennessee, they were starting to close down or were at risk without bailout money. There is some concern that the whole system is quite fragile now, given the sheer number of uninsured.

QUESTION FROM DR. WILLIAM BRENNER

I have a problem with your study being entitled "The Kaiser Commonwealth Study," with Kaiser getting top billing. To me it's analogous to the "GM Commonwealth Study of Auto Safety." Even though there's a dissociation between the Kaiser Family Foundation and its competing marketing entity, to me the Kaiser Family Foundation has been in the forefront pushing managed care over the last 40 to 50 years, and it's been their major goal. It does put into question the objectivity of any study where they get top billing in the title.

KAREN DAVIS

The Henry J. Kaiser Family Foundation has no connection with Kaiser Permanente or Kaiser Industries. The foundation is quite independent. I think your point is that Kaiser Permanente was founded in the late 1930s by Kaiser Industries, by Henry Kaiser, out of a desire to make sure that his workers had good health care, and then was expanded as part of the war effort in California in the shipbuilding industry in the 1940s.

One of the points that we are trying to emphasize in our work is the importance of differentiating the performance of different types of managed-care plans. Kaiser Permanente, for many of us, was the flagship health maintenance organization. It is a nonprofit, group staff model organization. Much of our research to date has been based upon plans like Kaiser Permanente and the Harvard Community Health Plan, which were in the forefront of the industry. In the last 10 years, managed care has grown to embrace many different forms. For-profit forms of managed care have grown rapidly; the group and staff model that used to dominate the industry is now a minority of the enrollment in managed care.

We must all become more sophisticated about what "managed" care means. It is not just Kaiser anymore; it is all forms of managed care. We must refine our research to look at it. Let me just stress, however, that our current work is a partnership with the Henry J. Kaiser Family Foundation, which is quite separate from both Kaiser Permanente and Kaiser Industries.

QUESTION FROM MARK WOLF, AMERICAN MEDICAL ASSOCIATION

Much of what you have talked about has to do with uncompensated care provided by hospitals. Have any of your surveys addressed the issue of identifying uncompensated care by individual physicians, or physician groups, or other health care professionals, and what effect that might have on access to care?

DAVID SANDMAN

Several Fund projects look at that. Recently, the Fund published its National Survey of Physician Experiences with Managed Care, which examined the day-to-day life of community-based practicing physicians, both generalists and specialists. It examined a range of ways in which managed care had affected their practices, their interactions with their patients, and with the plans. The study includes a section on physicians' ability to continue providing uncompensated care. Individual physicians should contact the fund to get the full report.

Another project, based in New York City, is being done with the United Hospital Fund. We are examining the implementation of Medicaid managed care in terms of the impact on patients, providers, and plans. That project is just entering its second phase.

KAREN DAVIS

One of the points that Mr. Sandman raises, which came up in the Commonwealth Fund Survey of Physician Experiences with Managed Care, is that we are becoming more proficient at defining and measuring underservice in the uninsured population. One of the themes of this symposium is the underserved, including those who may even be in managed-care plans. In the survey, physicians are reporting their difficulty in referring their patients to specialists, in getting patients who need it to physical therapy services, or mental health services, or rehabilitative services. Generally, they are reporting that it is difficult to get extensions of care for patients with specialized needs. We are going to have to advance the state of the art of measuring underservice in the uninsured. How do we measure it, even for people who have insurance or are covered by managed-care plans?

CATHY SCHOEN

It should be mentioned that there is a flip side to the issue of patients saying that their physicians do not spend enough time with them. Physicians in this survey were reporting that the amount of time they can spend with patients is going down dramatically, particularly where they serve either a Medicaid population or a heavy managed-care population. Patients can get in the doors, but still have an access problem.

QUESTION FROM DENISE SOFELD, COMMUNITY SERVICE SOCIETY OF NEW YORK

I am interested in the issue of primary care capacity in underserved neighborhoods. We have been told that the market and the financial incentives of managed care will help create primary care capacity in neighborhoods where it has been inadequate. Does managed care, in fact, through market mechanisms and financial incentives, enhance the capacity of primary care in previously underserved communities?

KAREN DAVIS

Economists have long believed if you build the field they will come, particularly if the financing is there so that the capacity can be developed. That is an important issue to watch in New York City. The United Hospital Fund research consortium with New York University and Columbia University has shown that when some companies have come into Medicaid managed care their first instinct has been to expand capacity, to build some primary care centers. But then, as the fiscal pressures on that program become evident (leaving aside the level or the appropriateness of the rates), you may see a reduced willingness to build and expand that capacity. You are identifying a very important point, and one of the things that the Fund will be looking for from that study.

DENISE SOFELD

I do not think there will be a simple answer to that because of the financing issue. Minnesota made a special effort to both pay plans that had a disproportionate number of sicker patients, more to reflect who they were serving, and to worry about their safety net urban clinics. As a result of that, you could see an expansion over time, but it was a very deliberate policy to not penalize a plan that was having a higher proportion of mental health, AIDS, and other problems with a rate structure that did not allow them to expand.

QUESTION FROM DR. GARCIA SOTTO, MEDICAL DIRECTOR OF PROMESA, A COMMUNITY-BASED MULTISERVICE AGENCY

Part of your data shows no difference between the way insured and uninsured people grade their status of health. Also, working does not seem to make a difference in terms of the length of time people remain uninsured. Matching that to Mr. Sandman's data, it still seems that the preponderance of access, whatever that might be, is through emergency rooms or outpatient clinics and hospitals.

Is there any interest in looking at consumer patterns for health services? Your data tend to support what doctors say constitutes access, but what are patients accessing that is not making a difference in regards to their health status, from their perspective at least?

CATHY SCHOEN

It should be remembered that this is a low-income population; none of the groups that I discussed as continuously insured were continuous over a 2-year period. The point was that the uninsured are not all healthy people, and that that group moves into insurance status, and the insured group moves back out.

I think your question is, What happens if people do not have insurance over a very long time? Do they get sicker? The answer is probably yes. Medicaid is available; one of the ways that people get on Medicaid is, if they get sick enough and lose all their money, they get coverage. Medicaid picks up a dramatically disproportionate share of sick people: 80% of those with private coverage are in excellent or good health, but half of those on Medicaid are in fair or poor health. The private sector is not picking up that group. There is a dynamic that pulls the sickest back in when their health deteriorates to the extent they really can't work. The groups are not stable; it's not the same people all the time.

QUESTION FROM MARK HENNEY, METRO NEW YORK HEALTH CARE FOR ALL CAMPAIGN

I have a question for those who have been surveying the uninsured people themselves. This information that we're hearing today is providing some ammunition for those of us that do public policy advocacy work. In surveying the people, however, are you just checking some of the demographic data, or are you looking at whether they are developing a political awareness? What are

their political attitudes about why they're in the situation that they're in; where do they place the blame; what do they think the solutions to their problems are?

CATHY SCHOEN

The surveys that we have discussed are not doing that, but we have a National Health Insurance Survey—the last one was done in 1993—that has questions about people's attitudes about expansion and what they would be willing to pay that cut across all income groups. It surveys their worries, both current and in the future, but none of our surveys are designed to actually raise awareness.

We are finding that people nationally, across all income groups and political parties, are still as concerned as they were when there was a big push for reform, and they are supportive of expansion. Popular support did not die. People are aware that if you don't have insurance, you're in trouble, especially if you're sick. I am not sure that awareness is necessarily as critical as much as is devising strategies that people could reach consensus around as potential solutions. There was actually fairly strong support for tax increases in the most recent survey, but we are only getting the results back now.

MARK HENNEY

What I was asking is, Do people, as they move into a state of uninsurance, become more aware politically about why they're in that situation? A general survey tells us one thing about the entire population, but is there any kind of awareness, consciousness raising, to use a 60's term, that's happening in those folks?

QUESTION FROM RICHARD STAYER, NASSAU COUNTY

With the pressures to reduce the numbers of residency programs, is it not possible that the public hospital sector may find it even more difficult to provide care for the underserved?

BRIAN BILES

I think that is right. Our work shows that there is a great deal of overlap between the indigent-care institutions and the academic institutions. There are pressures on uncompensated care, as we know from our analyses of such care in New York, and Washington, Los Angeles, Chicago. Your point is on the academic side: do we not have the same pressures? We have discussions about too many doctors, particularly too many of the wrong kind of doctors. I think you are exactly right. The funds, either for indigent care here or for academic missions, are essentially fungible. The pressures come on both sides simultaneously, so as we look ahead we can certainly be concerned.

QUESTION FROM JUDY FARRELL, HEALTH AND HUMAN SERVICES

At the state and local level, there have been discussions about the possibility of bringing for-profit companies into New York State to manage hospitals and, at

the local level, of privatizing public facilities. What do you think the implications are for the uninsured if that were to happen in New York State and at the local level?

KAREN DAVIS

The numbers suggest that the predominant providers of care to the indigent uninsured or to Medicaid patients are very heavily the public and the not-for-profit institutions. On one hand, therefore, you would be concerned with a shift across that spectrum. On the other hand, some studies show that there is a broad range of nonprofit institutions, and that they vary in their commitment to uncompensated care. There is at least some preliminary indication that the nonprofit institutions most likely to become for-profit organizations are those that, in fact, never provided much in the way of uncompensated care in the first place, perhaps because of where they are located geographically or for other mission reasons. This is an area in which the changes are very new, very rapid, and there is a lot of work yet to be done.